THOMAS A. DRAZIN, M.D.
Neurology

September 17, 2004

Ms. Christine Matkin
State of Hawaii
Department of the Attorney General
Civile Rights Litigation Division
425 Queen St.
Honolulu, Hawaii 96813

RE: LEROY KEMP V. STATE OF HAWAII, ET. AL.
Civil No. 02-1-1282-0
DOV: September 15, 2004

Dear Ms. Matkin:

I performed an Independent Medical Examination on Leroy Kemp on September 15, 2004. I have reviewed all of the records that you sent to me prior to the evaluation. Mr. Kemp is a 47-year-old right-handed gentleman who has had seizures since 1997. He had head trauma secondary to a fall in 1995, as well as previous head traumas during his younger years. He denies having any seizures prior to 1997. He initially was placed on Dilantin at the Queen Emma Outpatient Clinic, and was eventually seen by Dr. Leah Ridge, M.D., a neurologist at Pali Momi Medical Center after he had a seizure on 10/16/01. The patient stated that he had a seizure secondary to not being given his Dilantin on time. When reviewing the records it seems Dr. Leah Ridge thought that with no loss of consciousness or grand mal type of movements, that it was more likely a pseudoseizure. He did have an EEG done on the day of the seizure that revealed a normal study without evidence for seizure focus. He was placed on Lamictal 150 mg b.i.d. but continued to have several seizures thereafter. He has had a multitude of seizures including one on 8/28/02 whereby he had a stat Prolactin level which was normal. He was seen on 4/6/03 after a seizure and he had low levels of phenobarbital and tegretol. However, on 4/8/03 he had normal levels of phenobarbital and tegretol. He also had a prolactin level on 4/6/03, again which was normal. He had an EEG report on 4/10/03 which revealed no evidence for seizure activity.

EXHIBIT "A"

Queens Physicians Building II • 1329 Lusitana Street, Suite 702 • Honolulu, Hawaii 96813
Tel: (808) 536-7042 • Fax: (808) 536-7084

He was discharged with the final diagnosis of pseudoseizures, history of major seizure disorder. It was also suggested by Dr. Ridge that they try to give him IV normal saline with the next seizure as a placebo.

On 8/3/04, while he was going for an MRI scan of his cervical spine, he had a presumed seizure at the hospital on 8/3/04, although those records were not reviewed. After the MRI scan on 8/4/04, which revealed multi-level degenerative disease, he saw Dr. William Obana, a neurosurgeon, who thought surgery was not indicated.

PRESENT COMPLAINTS: There are no headaches, dizziness, or visual complaints at the time of my exam. He does state that the entire left arm is "weak". He also complains of neck pain. In a handwritten letter from the claimant, he states that the left knee full reconstruction was due to wrongful prescribed medications. His loss of his teeth was due to a hairbrush put in his mouth during a seizure. The left arm weakness from being handcuffed to a bed, including a pinched nerve in his neck.

PAST MEDICAL HX: Significant for depression, methamphetamine dependence, brown spider bite with partial amputation of the distal left thumb. Pseudoseizures. Dislocation of the left knee with status post knee replacement this year. History of fracture of the right arm. Gunshot wound to the left arm, hand, and chest, with chronic weakness. There has been no history of febrile seizures as a child.

ALLERGIES: None.

MEDICATIONS: Lamictal 150 mg b.i.d. and tegretol 250 mg b.i.d.

FAMILY HX: Unremarkable for neurologic disease or seizure disorder.

REVIEW OF SYSTEMS:

General: No fever, chills, or weight loss.

Respiration: No coughing, sneezing, or hemoptysis.

GI: No diarrhea, constipation, or recent change.

GU: No incontinence of urine. No dysuria, hematuria, or increased or decreased frequency.

Musculoskeletal: No edema or swollen joints.

Hematologic: No bleeding, bruising, or infections.

Skin: No rashes, ulcers, or vesicles.

Cardiac: No palpitations, chest pain, or shortness of breath.

Endocrine: No change in temperature tolerance, polydipsia, or polyuria.

RECORDS REVIEWED:

1. All State of Hawaii Department Public Safety notes from Halawa Correction Facility.
2. Pali Momi Medical Center notes.
3. Queen's Medical Center notes.
4. Leah Ridge, M.D.'s, notes.
5. Diagnostic Laboratory Services.

PHYSICAL EXAM:

He is a 47-year-old right-handed gentleman in no acute distress. He is shackled at the legs. He wears a wrist brace on the left hand.

SKIN: He has a well-healed scar in the middle of the forehead. He also has partial amputation of the distal thumb on the right side. He has a scar over the ulnar aspect of the left hand.

CRANIAL NERVES: He does have 2 to 3 beats of nystagmus in the horizontal plane bilaterally. Extraocular movements are otherwise full. The rest of the cranial nerves II-XII are normal. He does have poor dentition.

MOTOR: He has functional give-away weakness in the ulnar, radial, and median aspects of the entire left arm. He also has contralateral weakness in the right hand when trying to examine the left hand. He does have chronic atrophy of the ulnar enervated muscles with fasciculations in the hypothenar muscles on the left.

SENSATION: Non-dermatomal sensory abnormalities throughout the entire left arm.

REFLEXES: Deep tendon reflexes are 2 biceps and triceps, 2+ at the brachioradialis bilaterally. The patellar was not examined secondary to artificial left knee. His left leg stays in an extended position.

These are answers to the following questions that you wrote in the letter dated September 13, 2004.

1. (a) Diagnsosis and (b) prognosis of Plaintiff's present medical conditions, injuries, or symptoms.

Diagnosis: Pseudoseizures with the remote possibility of an underlying seizure disorder. It is clear from reviewing the records that he has had pseudoseizures from the description

of the activity including no loss of consciousness, no postictal phenomena, both of which are atypical symptomatology for a generalized seizure disorder. Other objective evidence excluding seizures are normal prolactin levels immediately following the seizure and at least two normal EEG's in the past. Dr. Leah Ridge, his neurologist, also states in the note that she believes he has pseudoseizures and recommended IV saline injections at the time of the seizure as a placebo treatment.

The claimant's left upper extremity symptomatology including give-away weakness and nondermatomal sensory abnormalities is unrelated to a specific neurological diagnosis. He does have some chronic weakness, particularly in the ulnar enervated muscles from his previous gunshot wound. He does have underlying cervical degenerative disease and spondylosis that was addressed by Dr. William Obana and thought not to be a surgical problem. He had a left knee replacement by Dr. Calvin Oishi for a previous dislocation degenerative problem dating back many years. Unclear how this is related to a pseudoseizure or seizure disorder.

In the Queen's Medical Center admission note dated 8/18/00, he did report that he had a history of a seizure disorder and has been off Dilantin and phenobarbital per his report for six months, and his by report to Dr. Lau for three years. He stated in the initial intake that there was no seizure activity in two years, and he reported to Dr. Lau that there was no seizure activity in three years off of anticonvulsants.

Pseudoseizures usually carry a fair prognosis unless they are treated head-on by psychologists or psychiatrists. It is also true that a few patients with pseudoseizures also have an underlying true seizure disorder and this needs to be ruled out in this claimant. The overall prognosis for pseudoseizures is good.

2. Whether the medications Plaintiff were prescribed for his alleged seizure disorder were reasonable and appropriate.

Yes. If the patient does have a true underlying seizure disorder, medications prescribed are reasonable and appropriate. It is unusual to have breakthrough seizures on multiple

anticonvulsants, which this claimant has, in light of the fact that he had at least two normal EEG's. Usually patients that have breakthrough seizures on multiple anticonvulsants have significantly abnormal EEG's as a baseline. It seems that this claimant had seizures at opportune times such as the last seizure in August of this year while he was at the hospital having his MRI scan. Emotional stress can cause symptoms that look like a true seizure disorder and can fool even the best of healthcare facilitators. It must be understood that pseudo seizures are real conditions that arise in response to stressors and patients are not necessarily faking them.

3. Whether the treatment of Plaintiff's seizure disorder while Mr. Kemp was incarcerated was reasonable and appropriate.

From what I have seen in the record review, it seems like his treatment of seizures were reasonable and appropriate, although it is difficult to teach an infirmary the difference between a pseudoseizure and real seizures. They have treated most of these episodes as if they were real seizures. It is my opinion that the claimant may be over-treated pharmacologically if these are pseudoseizures.

4. The causation, if any, between the Plaintiff's seizures and the care and treatment rendered by the physicians at the Halawa Correctional Facility.

With a reasonable degree of medical probability, the Plaintiff's seizures are unrelated to his incarceration at the Halawa Correctional Facility. There is increased stress in the facility which may bring on more of his pseudoseizures which would be very difficult to correct without psychological intervention. These psychological factors underlying pseudoseizures can be best identified with the help of those with special training in psychological issues, and clinical social workers. Most of the treatment involves psychotherapy, stress reduction, biofeedback, and personal support to help cope with these seizures. This is probably unreasonable for a correctional facility to undertake. There are no clear medications that would be appropriate for true pseudoseizures. The claimant will have pseudoseizures whether he has pharmacological treatment or not, depending on the severity of his stress reaction.

5. Please identify any pre-existing events or factors that my have caused, contributed to, or exacerbated Plaintiff's current disorder.

If the patient does have a true underlying eptileptogenic seizure disorder, this was caused from previous head trauma that was clearly stated in the patient's interview and medical review. Posttraumatic generalized epilepsy is a well-recognized disorder that can be treated with anticonvulsants. With a reasonable degree of medical probability, it is unlikely that one can go seizure free for three years without medications, and then while on multiple medications have recurrent seizures, which makes the diagnosis of pseudoseizures more likely. Certainly, the stress situation of being incarcerated contributes the claimant's current pseudoseizure disorder.

The most precise way to exclude a true underlying generalized seizure disorder is with 24-hour monitoring, either with or without video. He can be hooked up with a ambulatory EEG for one to three days to see if there is any abnormal eptileptogenic activity, or a 24-hour inpatient stay with electrode and video monitoring which is clearly the most precise way to define a diagnosis of pseudoseizure disorder. This can be scheduled at Queen's Medical Center Surgery Center. If in fact Dr. Leah Ridge and my diagnosis is correct with pseudoseizures, then the idea that he was denied proper medication for his seizure disorder is a moot point as he would not need medications for these episodes presently or in the future. I have also taken the liberty to get an tegretol level today along with a CBC to be forwarded to Dr. Leah Ridge to see if he was taking his medications and whether his levels are normal.

If you have any questions or concerns regarding this report do not hesitate to contact me at my office.

Sincerely,

Thomas Drazin, M.D.

TD:idg

LABORATORY REPORT

DIAGNOSTIC LABORATORY SERVICES, INC.

650 IWILEI ROAD, SUITE 300
HONOLULU, HI 96817 • TELEPHONE 589-5100

CLIENT
DRAZIN, THOMAS A. M.D.
THE QUEENS P.O.B. II
1329 LUSITANA ST. #702
HONOLULU, HI 96813

PATIENT
KEMP, LEROY
DR.: DRAZIN, THOMAS

PAT.TEL#: 4862600 EXT 42

AGE, DATE OF BIRTH: 47, 03/07/1957
SEX: M
PATIENT ID: 572083874
DATE COLL.: 09/15/2004 09:48
REPORT DATE: 09/15/2004 01:36PM
ACCESSION: S9818260
PAGE 1

Tests	Results			Reference Values
CBC w/ Plt Ct				
White Blood Count	8.5		x10(9)/L	4.8-10.8
Red Blood Cell Count	4.77		x10(12)/L	4.00-6.20
Hemoglobin	14.4		g/dL	14.0-18.0
Hematocrit	43.4		1/L	42.0-52.0
MCV	91.1		fL	82.0-101.0
MCH	30.3		pg	26.0-34.0
MCHC	33.3		g/dL	32.0-36.0
Neutrophil	62		%	40-80
Band	NORM		%	0-6
Lymphocyte	24		%	12-44
Monocyte	8		%	0-12
Eosinophil	5		%	0-7
Basophil	1		%	0-2
Platelet Count	264		x10(9)/L	140-440
Anisocytosis	1+	H		NONE
Abs Neutrophils	5.21		x10(9)/L	1.80-7.70
RDW	16.7	H	%	<14.5
Carbamazepine (Tegretol)	12.6	H	ug/mL	8.0-12.0
Hepatic Function Profile				
SGOT (AST)	30		IU/L	0-37
SGPT (ALT)	30		IU/L	0-40
Alkaline Phosphatase	85		IU/L	33-130
Bilirubin, Total	0.5		mg/dL	0.2-1.5
Bilirubin, Direct	0.1		mg/dL	0.0-0.3
Total Protein	7.8		g/dL	6.2-8.2
Total Protein normal reference range has been adjusted effective 06/28/04.				
Albumin	3.9		g/dL	3.4-5.0
Bilirubin, Indirect	0.4		mg/dL	0-1.3

* An ADDITIONAL REPORT has been sent as requested to:
- RIDGE, LEAH M.D. 98-1079 MOANALUA RD., #650

*** FINAL REPORT ***

FORM F-305 11/01

Immunohematology, Coagulation testing regularly performed at 1301 Punchbowl Street; all other testing performed at 650 Iwilei Road unless otherwise indicated.